

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03870

3857

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Bloomery		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
3. NAME OF DECEASED (Type or print) Ethel		First Annie	Middle Andrews
4. DATE OF DEATH April		Month 12	Day Year 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1889
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Sussex Co., Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Washington Reeves	
14. MOTHER'S MAIDEN NAME Annie (maiden name unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-12-0160		17. INFORMANT Charles E. Andrews, Federalsburg, Md., R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 8 days  DUE TO (b) Generalized arteriosclerosis Cerebral hemorrhage DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10, 1949, to Aprt 12, 1957, that I last saw the deceased alive on Apr 13, 1957, and that death occurred at 3:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Lennon, M.D.		ADDRESS (Street, city or town, state) Federalsburg, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF April 15, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery	
22d. LOCATION (City, town, or county) Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE April 15, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24b. REGISTRAR'S SIGNATURE Margret H. Frampton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILSON COUNTY GOVERNMENT OF KANSAS - SEDGWICK, KS

BUREAU K-5

APR 22 1957

REGISTRY

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03871

Reg. Dist. No.

3868

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XI Ridgely</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garland Lake</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Claudell</b>	Middle <b>Eugene</b>	Last <b>Blades</b>	4. DATE OF DEATH <b>April</b>	Month <b>14</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> August 29, 1929</b>	9. AGE (In years last birthday) <b>27 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Staff Sgt. Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Air Force</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W. Vernon Blades</b>		14. MOTHER'S MAIDEN NAME <b>Della Knox</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Since 1951</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>W. Vernon Blades, Ridgely, Maryland</b>		Address <b>Ridgely, Caroline Co., Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowning - accidental</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b></span>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>823X</b> <span style="float: right;"><b>few hours</b></span>							
(b) <b>Concussion of Brain</b>							
(c) <b>Automobile accident</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident - Struck on Abutment + into Lake</b>					
20c. TIME OF INJURY Hour <b>1:26 p.m.</b>		Month, Day, Year <b>4-14 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Ridgeley</b>	(County) <b>Caroline Co.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dawson D. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4-17-57</b>			
EXAMINER'S NAME (Type) <b>Dawson D. George</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) <b>Federalsburg, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>4/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson D. George</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 18 1957

BUREAU V. A.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3869

## CERTIFICATE OF DEATH

03872  
47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berkeley</i>	c. LENGTH OF STAY IN 1b <i>6 weeks</i>	b. COUNTY <i>Talbot</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>20x12 Rural Cordova</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>FRANK</i>	Middle <i></i>	Last <i>BOYLES</i>	4. DATE OF DEATH <i>APR. 17</i>	Month <i>17</i>	Day <i>1957</i>	Year <i>1957</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>AUG 1, 1892</i>	9. AGE (In years less birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm owner</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>William C. Boyles</i>	14. MOTHER'S MAIDEN NAME <i>Rhoda Brown</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Carolyn Harry Denton, kd.</i>	Address <i></i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
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PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>191X</i>	DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.  (b) <i>Innumous of left lower lobe 2 days</i>
	DUE TO  (c) <i>Metastatic carcinoma of the neck gland</i>
	<i>Caesions of the left upper lbd 2 year</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus. Enlargement of left leg</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
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21. I certify that I attended the deceased from <i>March</i> , 19 <i>57</i> , to <i>April</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>April 16, 1957</i> and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.
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ACTUAL SIGNATURE <i>Kurt Leiserer</i>	M.D. <i>Quebec Univ</i>	ADDRESS (Street, city or town, state) <i></i>	DATE SIGNED <i>4-19-57</i>
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PHYSICIAN'S NAME (Type) <i>KURT LEISERER</i>	MARYLAND
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 20, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Greenmount</i>	22d. LOCATION (City, town, or county) <i>Talbot</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Carolyn Harry Denton, kd.</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>4/20/57</i>	24b. REGISTRAR'S SIGNATURE <i>Wm. O. George</i>
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CERTIFICATE OF DEATH

BUREAU V.  
REGELIVEO  
APR 24 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
**3870**

03873

Reg. Dist. No. 64

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near American Corner</b>						d. STREET ADDRESS <b>Near Nichols</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Retha</b>		First <b>Retha</b>	Middle <b>Louise</b>	Last <b>Haynes</b>	4. DATE OF DEATH <b>April 20 1957</b>	Month <b>April</b>	Day <b>20</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1925</b>		9. AGE (In years last birthday) <b>32 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis Henry Haynes</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Green</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. <b>220-05-1859</b>		17. INFORMANT <b>Corenia M. Cook, Preston, Md., R.F.D.</b>		Address			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Shock - Multiple Fractures		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
812 X		(b) DUE TO  Automobile accident							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by Automobile</b>							
20c. TIME OF INJURY Hour <b>3</b> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Rural Federalsburg Caroline Md</b>		(County) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dawson D. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4-23-57</b>	
EXAMINER'S NAME (Type) <b>Dawson D. George</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Harmony Cemetery</b>		22d. LOCATION (City, town, or county) <b>Near Preston, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 4-23-57</b>		24b. REGISTRAR'S SIGNATURE <b>Margaret H. Frampton</b>			
VS. ATSMC(S) SM 9/55									

RECEIVED  
FBI - NEW YORK

APR 26 1957

BUREAU V-3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3871

## CERTIFICATE OF DEATH

03874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN lb 65 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Rev. Noble		First N.	Middle Henry
4. DATE OF DEATH 4 Month 25 Day Year 57 19		5. SEX Male	
6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/16/1892		9. AGE (In years last birthday) yrs. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Henry		14. MOTHER'S MAIDEN NAME Ida Lockerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rosa J. Henry		Address Henderson, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Renal Disease with hypertension  DUE TO hypertension  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 22, 1957, to Apr. 23, 1957, that I last saw the deceased alive on Apr. 23, 1957, and that death occurred at 3:40 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Chas. H. Stonesifer, M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/57	
22c. NAME OF CEMETERY OR CREMATORIAL Union Goldsboro		22d. LOCATION (City, town, or county) Goldsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire Greensboro, Md.		ADDRESS DATE 4/26/57	
24a. REC'D BY REGISTRAR J. C. Smith		24b. REGISTRAR'S SIGNATURE	

DEPARTMENT OF DEFENSE—HEADQUARTERS  
CERTIFICATE OF DATA

BUREAU  
RECEIVED

APR 29 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03875

3872

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Denton</i>		c. LENGTH OF STAY IN 1b. <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i></i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>A. MANDA</b>		First <i>JANE</i>	Middle <i>MURRAY</i>
4. DATE OF DEATH <b>APRIL</b>	Month <b>21</b>	Day <b>Year</b> <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 13, 1859</b>
9. AGE (In years from birthday) <b>78 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Samuel [Unknown]</i>		14. MOTHER'S MAIDEN NAME <i>Hester Murray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>(Yes) Hester N. Murray Denton, Md.</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yr</b>	
45 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>Feb 8 1957</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State) <i></i>	
21. I certify that I attended the deceased from <b>Feb 8 1957</b> , to <b>April 19 1957</b> , that I last saw the deceased alive on <b>April 19 1957</b> , and that death occurred on <b>11:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Paul Knotts</i>		ADDRESS (Street, city or town, state) <i>Denton, Md.</i>	
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>		DATE SIGNED <i></i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial Apr. 27 1957</i>		22b. DATE THEREOF <i></i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Springside</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Neeson, Denton, Md.</i>		24a. ADDRESS <i></i>	24b. LOCATION (City, town, or county) <i>Denton, Md.</i>
		24c. REC'D BY REGISTRAR <i></i>	24d. REGISTRAR'S SIGNATURE <i>M. George</i>
		DATE <b>4/26/57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02876  
*(Handwritten)*

3873

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abraham		First C. Note	Middle Last
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Note		14. MOTHER'S MAIDEN NAME Eliza E. Jr.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 194-20-8801	
17. INFORMANT Mrs. Joseph McCoy, Marydel, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cardiovascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH	
{ IMMEDIATE CAUSE (a) X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cardiovascular Renal Disease		(c) General Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1957, to April 19, 1957, that I last saw the deceased alive on April 18, 1957, and that death occurred at 6:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Charles H. Stonesifer</i> M.D. ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 4-19-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/57	
22c. NAME OF CEMETERY OR CREMATORIUM Fernwood		22d. LOCATION (City, town, or county) (State) Delaware County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire</i>		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR DATE 4-18-57		24b. REGISTRAR'S SIGNATURE <i>A. C. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.  
RECEIVED

MAY 6 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3874

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

03877

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Greenridge Road				d. STREET ADDRESS 206 Greenridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Annie	Middle Elizabeth	Last Spicer	4. DATE OF DEATH April 12 1957	Month April	Day 12	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1887	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Federalburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James H. Davis			14. MOTHER'S MAIDEN NAME Annie V. Wright					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (See no. or unknown) <input type="checkbox"/> No			16. SOCIAL SECURITY NO. None		17. INFORMANT James O. Spicer, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			Carcinoma ch. breast & Generalized metastasis INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Federalburg	(County)	(State)	
21. I certify that I attended the deceased from <u>Oct 1, 1956</u> to <u>4/12, 1957</u> , that I last saw the deceased alive on <u>4/12, 1957</u> , and that death occurred at <u>9:40A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Federalburg, Md.</u> DATE SIGNED <u>4/15/57</u>								
ACTUAL SIGNATURE <i>Frank M. Anderson, M.D.</i>		PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 16, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery	22d. LOCATION (City, town, or county) Federalburg, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE April 15, 1957	24b. REGISTRAR'S SIGNATURE Margaret H. Frampton			

BUREAU Y.

8 22 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03878

3875

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bethlehem</b>				d. STREET ADDRESS <b>Bethlehem</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First <b>Harry</b>	Middle <b>Miller</b>	Last <b>Towers</b>	4. DATE OF DEATH	Month <b>April</b>	Day <b>6</b>	Year <b>1957</b>	
S SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>February 7, 1885</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Abraham Towers</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Murphy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Mrs. Lura M. Towers, Preston, Md., R.F.D.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b)  DUE TO  (c)				Chronic Cardiac衰弱 Generalized Arteriosclerosis The Cirrhotic condition				INTERVAL BETWEEN ONSET AND DEATH <b>17 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Right hemiplegia</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Preston</b>		(County) <b>Md.</b> (State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>April 11, 1952</b> , to <b>April 16, 1957</b> , that I last saw the deceased alive on <b>April 11, 1957</b> , and that death occurred at <b>8:35 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Jacq B. Plummer</b>		M.D.		ADDRESS (Street, city or town, state) <b>Preston Md. 21620</b>		DATE SIGNED <b>14/9/57</b>		
PHYSICIAN'S NAME (Type) <b>Harcyle B. Plummer</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						
22b. DATE THEREOF <b>April 10, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Junior Order Cemetery</b>		22d. LOCATION (City, town, or county) <b>Preston, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>4-9-57</b>		24b. REGISTRAR'S SIGNATURE <b>Cornelia W. Plummer</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

APR 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3876

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

(13829)

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, filling the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL RIDGELY</b>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL RIDGELY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELWOOD</b>	Middle <b>C.</b>	4. DATE OF DEATH <b>Month APR. Day 7 Year 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>AUGUST 25, 1914</b>	9. AGE (In years last birthday) <b>42 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chicken</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>JERRY</b>		14. MOTHER'S MAIDEN NAME <b>MARYIE MATTHEWS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 218070290</b>	17. INFORMANT <b>Jessie Seth Ridgely, husband</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 400.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>Decedent</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Hanson D. George</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/7/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 9, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Henry Farm</b>	22d. LOCATION (City, town, or county) <b>Ridgely, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Moore &amp; Son, Pottow, Md.</i>		ADDRESS <b>ADDRESS</b>	24a. REC'D BY REGISTRAR <b>DATE 4/9/57</b>
			24b. REGISTRAR'S SIGNATURE <b>Modo George</b>

BEREAU V.

APR 11 1957

REGELIV E

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by a hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3877

Item 6 Film G214 5-7-57 et

03880 62

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN lb <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>	
3. NAME OF DECEASED (Type or print) <i>Margaret</i>		First <i>Margaret</i>	Middle <i>Wiley</i>
4. DATE OF DEATH <i>Dec 28, 1957</i>		Month <i>Dec</i>	Day <i>28</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 29, 1874</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cooking</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Nathan Corkran</i>		14. MOTHER'S MAIDEN NAME <i>Sue Blodges</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Roger Dukes, Denton, Md</i>		Address <i>Denton, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>431X Myocarditis Acute</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Renal suppression</i>		2 days-	
(c) <i>Cystic ovary</i>		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-18, 1957</i> , to <i>4-28, 1957</i> , that I last saw the deceased alive on <i>4-28, 1957</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Dawson O. George M.D.</i>		ADDRESS (Street, city or town, state) <i>Denton, Md</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Dawson O. George</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>May 1, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Holts</i>	
22d. LOCATION (City, town, or county) <i>Holts</i>		(State) <i>Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Moore Son, Denton</i>		ADDRESS <i></i>	
		24a. REC'D BY REGISTRAR DATE <i>5-1-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Tom &amp; O. George</i>	

WISCONSIN STATE GOVERNMENT OF HERITAGE-CULTURE-ARTS  
CERTIFICATE OF DATA

DATA

BUREAU Y. S.

MAY 3 1957

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